CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 08/05/2011 FORM APPROVED OMB NO. 0938-0391

	STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155332		A. BUILDING		NSTRUCTION 01	(X3) DATE SURVEY COMPLETED 07/19/2011	
NAME OF PROVIDER OR SUPPLIER HERITAGE HOUSE REHABILITATION & HEALTHCARE CEN			STREET ADDRESS, CITY, STATE, ZIP CODE 281 S CO RD 200 E				
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFIX TAG		PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPR DEFICIENCY)	D BE	(X5) COMPLETION DATE
K0000	A Life Safety Constate Licensure of the Indiana State accordance with Survey Date: 07 Facility Number Provider Number AIM Number: 1 Surveyor: Mark Specialist At this Life Safe House Rehability Center was found not in Requirements for Medicare/Medic 483.70(a), Life Scafety Code (LScafety	ode Recertification and Survey was conducted by Department of Health in 42 CFR 483.70(a). 7/19/11 : 000225 r: 155332	K	0000			
LABORATOR	Y DIRECTOR'S OR PROV	/IDER/SUPPLIER REPRESENTATIVE'S SIG	GNATURE		TITLE		(X6) DATE

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

(X6) DATE

Any defiencystatement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determined that other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

4ZWO21

Facility ID:

000225

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			NSTRUCTION 01	(X3) DATE SURVEY COMPLETED		
THIS TELLY OF CONDENSION		155332	A. BUII B. WIN			07/19/2011		
NAME OF PROVIDER OR SUPPLIER HERITAGE HOUSE REHABILITATION & HEALTHCARE CENT			STREET ADDRESS, CITY, STATE, ZIP CODE 281 S CO RD 200 E					
(X4) ID PREFIX TAG	(EACH DEFICIEN REGULATORY OR smoke detection spaces open to th	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION) in the corridors and the corridors. The facility 100 and had a census of		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	E	(X5) COMPLETION DATE	
	86 at the time of Quality Review by I Code Specialist-Med The facility was fou	this visit. Robert Booher, Life Safety dical Surveyor on 07/22/11. Ind not in compliance with the allatory requirements as						
K0044 SS=E	with 7.2.4. 19.2 Based on obser interview, the fensure 2 of 8 s were arranged 7.2.4.3.8 required doors to be sel automatic closis with 7.2.1.8. Not Standard for fire Windows at 2-4 closing mechanical adjusted to overesistance of the solution positive late each door oper deficient practice.	evation and acility failed to ets of fire doors to latch. LSC res fire barrier f closing or ng in accordance IFPA 80, the e Doors and Fire 4.1.4 requires all hisms shall be excome the lee latch mechanism hing is achieved on ation. This ce affects any the Therapy Hall I.	K	0044	The creation and submission this plan of correction does n constitute an admission by the provider of any conclusion set forth in the statment of deficiencies, or of any violation regulation. The provider respectfully requests that the 2567 plan of correction be considered the letter of credit allegation and request a post certification review on or afte 8/18/2011. What corrective action(s) will be accomplished those residents found to have been affected by the deficient practice? The (2) sets of fire of in question were rubbing on publid up and has been adjust for speed to ensure proper closure. If painting occurs in thallways where firedoors exist doors will immediately be checked to ensure proper latching. How will you identify	ot is is is on of ble if if doors caint ed the ist,	08/18/2011	

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STATEMENT OF DEFICIENCIES		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155332		ULTIPLE CO	NSTRUCTION	(X3) DATE S				
AND PLAN OF CORRECTION				LDING	01	COMPL 07/19/2				
100002		193332	B. WIN			07/19/20	011			
NAME OF PROVIDER OR SUPPLIER					STREET ADDRESS, CITY, STATE, ZIP CODE					
HERITAGE HOUSE REHABILITATION & HEALTHCARE CENTER			ER	281 S CO RD 200 E CONNERSVILLE, IN47331						
				ID			(X5)			
(X4) ID PREFIX	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL			PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		COMPLETION			
TAG		LSC IDENTIFYING INFORMATION)		TAG	CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	E	DATE			
K0056 SS=E	Based on observa a tour of the facil 1:00 p.m. with th supervisor, the T Hall sets of fire dinto the door frantattempts. Based maintenance super 11:00 a.m., the faconstructed with barriers equipped hour fire doors. Service Hall sets latch was verified supervisor at the acknowledged by 12:45 p.m. exit constructed in according to the service of the built properly maintaine 25, Standard for the Maintenance of W. Systems. It is fully reliable, adequate system. Required equipped with water the supervisor with the service of the se	ations on 07/19/11 during lity from 10:00 a.m. to be maintenance herapy Hall and Service doors each failed to latch mes on two separate on an interview with the ervisor on 07/19/11 at acility was originally eight, two hour fire d with one and one half. The Therapy Hall and of fire doors failing to d by the maintenance time of observations and the administrator at the onference on 07/19/11. Inatic sprinkler system, it is ance with NFPA 13, installation of Sprinkler de complete coverage for all liding. The system is each in accordance with NFPA are Inspection, Testing, and ater-Based Fire Protection to supervised. There is a water supply for the sprinkler systems are er flow and tamper re electrically connected to			other residents having the potential to be affected by the same deficient practice and vorrective action will be taken? The maintenance marks checked all fire doors on other areas and the fire doors close properly. What measure will be put into place or what systemic changes you will move to ensure that the deficient practice does not recur? Door be tested monthly when the falarm is activated and inspector properloperation, which includes closing and latching will the corrective action(s) be monitored to ensure the deficient practice will not recur, i.e., who quality assurance program where we will always a monthly basis. Maintena will audit closing of the fire domonthly. QA will review audit monthly for 6 months and members will determine if to continue. Mainttence to monitor. Deadline: 8/18/11	what all all ses ake rs will ire cted .How e cient nat ill be nitor ance				

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/		X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION		NSTRUCTION	(X3) DATE SURVEY		
AND PLAN OF CORRECTION		IDENTIFICATION NUMBER:	A. BUILDING 01		01	COMPLETED		
155332		155332	B. WIN		.5		07/19/2	011
					TREET A	DDRESS, CITY, STATE, ZIP CODE		
NAME OF PROVIDER OR SUPPLIER				2	81 S C	O RD 200 E		
HERITAGE HOUSE REHABILITATION & HEALTHCARE CENT				ER CONNERSVILLE, IN47331				
(X4) ID SUMMARY STATEMENT OF DEFICIENCIES				I	D	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIENCY MUST BE PERCEDED BY FULL			PRI	EFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG	REGULATORY OR	REGULATORY OR LSC IDENTIFYING INFORMATION)		T.	AG	DEFICIENCY)		DATE
	Based on observ	ation and interview, the	K0056			What corrective action(s) will be		08/18/2011
	facility failed to	ensure 1 of 78 rooms was				accomplished for those reside found to have been affected		
	provided with complete sprinkler			the deficient practice?Sprii		•		
	coverage. This deficient practice could					head was ordered on 7/19/1		
	affect any reside	nt using the main dining				from the sprinker system		
	1	jacent to the kitchen.				contractor PIPE. The sprinkler head is expected to be installed		
		3						
	Findings include					by PIPE no later that 8/18/11.How will you identify other residents		
	i mangs merade.					having the potential to be affected		
	Based on observation on 07/19/11 during a tour of the kitchen from 11:15 a.m. to					by the same deficient practic		
				and what corrective action			ill be	
				taken?77 of 78 rooms have				
	11:40 a.m. with the maintenance supervisor, the twenty foot dead end corridor near the food storage room pantry had one standard pendant sprinkler located twenty two feet from the end of the twenty foot dead end corridor with no					sprinklers as indicated on the		
					2567.What measures will be put into place or what systemic changes you will make to ensure			
						that the deficient practice do		
				not recur?Maintenance inspected the facility sprinkler heads(365)				
	other sprinkler coverage visible. Based on an interview with the maintenance supervisor on 07/19/11 at 11:30 a.m., the kitchen pantry corridor was identified as					from 7/19/11-7/20/11 and for no other voids in coverage.	ınd	
						Quarterly inspection will be done		
						by PIPE. They will check for		
						location and functionality.		
	needing additional sprinkler coverage by the sprinkler inspection contractor two							
	years ago, but it was not corrected. The lack of adequate sprinkler coverage in the							
	1	l end corridor in the						
	· -	nowledged by the						
		the 12:45 p.m. exit						
	conference on 07	_						
		// 1 // 11.						
	2.1.10(1)							
	3.1-19(b)							
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